**Meeting Summary**

**eHealth Technical Advisory Committee**
**November 30, 2009 12:30PM-1:30PM**

*Please refer to the meeting slides for additional information.*

Update from CHHS

Jonah Frolich gave an update from the eHealth Advisory Board. The state's HIE operational planning process was presented to the advisory board last week. There were two main concerns brought up by the board.

First, there was a question regarding oversight of the Technical Committee and how it would be receiving its guidance. As a point of clarification, the Technical Committee will ultimately be incorporated into the Governance Entity once that organization has been selected and put in place to manage and oversee the information exchange infrastructure that is supported by the federal grant. The Governance Entity will be responsible for providing the strategic direction for the Technical Committee. Until then, CHHS, the eHealth Advisory Board, and the Operations Team are playing this role. The membership of the Technical Committee is purposely targeted towards senior IT leadership representing major constituencies within the state who would have a vested interest in shared HIE services. The committee's makeup is aligned with the tasks before the committee, namely to propose a shared HIE architecture, to help CHHS understand what HIE services are in place today, and to give recommendations on what services should be supported as part of the HIE infrastructure.

A second concern of the Advisory Board is that the design process undertaken by the Technical Committee would not be informed adequately by the clinical processes the architecture is meant to support. On one hand, the charter clearly describes that priorities need to follow meaningful use, and clinical priorities are already being determined through the meaningful use incentives from the federal government via Medicare and MediCal payments. However, there was concern that there is no clinical or operations group that will be part of the larger framework of how HIE services will be expanded and supported in an ongoing basis. It will be important to look beyond the current limited federal opportunity and create an HIE infrastructure in California that is able to exist sustainably.

CHHS is therefore proposing to create a Clinical Operations Committee that will help inform and guide the work of the Technical Committee in the medium to long term along with the Governance Entity. Other workgroups, including the Disparities, Finance, and Patient Engagement Workgroups, will also help inform and guide the work of the Technical Committee. This way, the requirements proposed by other workgroups can be incorporated into the design of HIE services and the committee's deliverables. While Jonah has generated a short list of people who he believes will be good candidates to serve on the Clinical Operations Committee, he is open to suggestions for possible members from the Technical Committee.

Technical Committee Charter

The revised charter was sent out to the group following the last meeting. There were no additional comments or suggestions for changes to the charter during the meeting. The charter will therefore be considered finalized in its current form.

Meeting Schedule (Slide 6)

Members of the committee were sent a schedule of upcoming meetings. Although it is unclear whether the committee will continue to meet on a biweekly basis past April, members are requested to hold their schedules open for meetings through June.

Update on Technical Working Group and Public Review Group (Slides 7 and 8)

Members of the TWG were invited and confirmed last week, with the initial kickoff meeting scheduled for Dec. 1st to discuss goals and deliverables. A list of members will be circulated at the end of this week when membership has been finalized. The PRG is open to all interested parties and is intended to allow provide a channel for review and feedback throughout the design process. Technical Committee members are asked to notify others about this opportunity to participate, and to email estrydom@sujansky.com should they know of parties who would be interested. In addition, a bulletin will be sent out by CHHS asking those interested to sign up.

Background Research (Slides 9-10)

The committee has entered a period of initial background research which will last through the end of December. Input from members and other sources will be gathered regarding: (1) stakeholder requirements with respect to shared services for meaningful use, (2) existing HIE capabilities among various entities in the state, and (3) relevant technologies that may play a role in developing the design of a technical infrastructure. These research topics will be addressed with the help of TAC and TWG. Interviews with members will begin this week.

Communication Logistics (Slide 11)

An online collaborative project space is being set up for use by TAC. Shared documents, project calendar, email archives, and other project resources will be available on the space, which will be accessible at: http://chhsehealth.projectspaces.com (please note that this URL has changed since the meeting slides were distributed). User accounts will be created for each TAC member. Accounts for additional meeting participants can be created upon request. An email explaining how to use log in and use the tool will be sent to the committee when the space is ready for use. In addition, two email lists will be set up for use by the committee, one for discussion (tac-discuss@lists.projectspaces.com) and one for announcements (tac-announce@lists.projectspaces.com). Replies to the discussion list will be broadcast to the entire list, while replies to the announcement list will only go to the sender of the message.

HIE Architectural Choices: Connectivity Models (Slides 12-15)

Tim Andrews described three alternative connectivity models that were proposed in the state's strategic plan for HIE (available here). Members were reminded that this document represents the point of departure for the work of the Technical Committee.

The first part of the strategic plan described a set of shared HIE services at the highest level. Three statewide connectivity models were mentioned in the strategic plan as possible ways to accomplish this given a large state with many different entities, interests, and governance structures. The three models are:

1. Exclusive HIE Geographies Model. In this model, connectivity is provided by non-overlapping entities that have been granted exclusive geographic regions to provide HIE services. Thus, an HIE entity has exclusive province over a particular geography. Put together, these entities cover the entire state in a statewide network. Note that boxes depicting regions in the slides are illustrative, not descriptive. Entities can be public or private. An advantage of this model is that it is very clean and entity responsibility is completely clear—the entity is responsible for connecting everyone within a designated region. Shared services can be deployed across all entities and cover the entire state. Walter noted that the implication is that there is a single designated entity, depending on region, for anyone who wants to connect. Bill Spooner suggested that in this monopolistic model, there is no incentive for entities to keep costs down. Tim replied that this was correct, but that there is also evidence to suggest that multiple entities competing in the same space do not necessarily lead to lower costs.
2. State-supported Utility Model. In this model, some entity that the state sponsors takes on the role of "provider of last resort" for connectivity. The model attempts to address the reality that in California, there is a lot of "white space" in which there is no current HIE coverage and which may otherwise be difficult to fill in, particularly in rural areas. The existence of a state-supported entity would ensure that there would be at least one service available that everyone can connect to, wherever they might be located in the state. There can be overlap in connectivity coverage with other HIE entities, and there can be competition between entities.
3. Neutral connectivity model. Here, any entity, whether public or private can provide HIE services anywhere in the state, provided that it abides by the "rules of the road" defined by statewide standards and policies. This model is the most flexible, provides the maximum scaling ability, encourages competition and innovation, and allows for a lot of different situations that can accommodate the diversity of CA environment. Terri Shaw asked whether or not there were significant barriers to entry in this model, and what the process would be for an entity to enter the market. Tim replied that this would need to be determined by the state—one would certainly want to ensure that entities are following the rules of the road, and thus some sort of certification process would be possible, but this would need to be worked out.

The following discussion points about connectivity and HIE services were also brought up.

- Angela Roberts brought up the concern of providers being overburdened by needing to participate in more than one, and possibly several, entities providing HIE services. Currently, there are 3-4 HIEs that Altamed may be asked to participate in. Supporting participation in these is daunting given that all four HIEs use different data exchange standards. It would help if there was a mechanism to plug into a single HIE. The exclusive geographies model is appealing for this reason.

  In response to this concern, Walter stated that whatever model is selected, consumers of HIE services should not be required to support multiple ways to connect to such services. Tim responded that while technically true, problems can arise when standards are not well-defined and policy rules are not clearly articulated. In order for these models to be implemented such that the desired outcome is achieved, there must be requirements, for example, that every HIE must share with all other HIEs. Laura Landry stated that it will be critical to specify what services an HIE must provide and what minimum data they must exchange in order to avoid the situation that Altamed and others may find themselves in. Another example of this problem is with migrant workers, who travel through many regions with different pre-existing HIEs.

- One participant asked whether if in the neutral connectivity model, having a requirement that participants adhere to statewide standards and policies would automatically alleviate these issues. Tim answered that technical interconnectivity could be achieved yet still have issues of HIEs choosing not to share with others. It will therefore be critical for *policies* to address these issues to ensure that the network is open.

- Terri Shaw observed that there appear to be two separate types of issues. One set of issues has to do with enabling data exchange, while the other involves determining what information must be shared.

- Walter observed that the grounding of the current effort in meaningful use functions may naturally remove some barriers to data sharing, since this will bring together parties that presumably will already desire to share information in order to achieve meaningful use goals.

- Patrick Sonn-Shiong brought up the concern that trying to determine what information must be shared could lead to over-simplification of health data exchange such that interoperability needs are not truly met. In reality, the nature of what needs to be shared is very complex and agreeing upon a "lowest common denominator" approach of data exchange will prove to be inadequate.

- Tom Williams (online) asked whether there was a connectivity model involving only a single statewide entity. Walter responded that this model was not currently among those being considered due to the presence of existing HIEs in parts of California that have done significant work in bringing HIE to those regions; thus, supplanting these efforts is not a desirable option.

- Charles Kennedy (online) was not in favor of an exclusive approach because there is insufficient understanding as to what approaches work best. Therefore, to make a decision that results in an exclusive award would be irresponsible. He stated the need to promote competition and allow for different types of approaches, because sharing of information in and of itself may not accomplish much. Sharing information that is actionable and useful creates value, and getting there requires trying different strategies.
- Tim added that HIE driven by provider and patient demand will tend towards expansive rather than limited sharing.

Next Steps

1. Committee members are encouraged to continue the discussion over the email discussion list, tac-discuss@lists.projectspaces.com, which will be available before the end of the week.
2. A decision about a 12/29 meeting will be made based on member availability for that call, which will be determined over email. In any case, the next meeting will take place on 12/15.
3. An email will be sent in the next few days to each member with login info and usage instructions for the online project space.
4. Interviews with committee members will begin over the next week as part of the background research process.

Summary of Key Questions/Issues/Decision Points:

- It will be important to avoid placing undue burden on providers, requiring them to support multiple ways of connecting to HIE services in order to share data. How should the technical architecture be designed in conjunction with appropriate policy to ensure that data is shared?

- Should there be a policy requirement for entities engaging in HIE to share a certain minimum set of information? Does the common goal of achieving meaningful use obviate this?

Members Present

| Name | Title and Organization |
|---|---|
| Bill Beighe | CIO, Physicians Medical Group of Santa Cruz |
| Zan Calhoun | CIO, Healthcare Partners |
| Molly Coye | CEO, CalRHIO |
| Jonah Frolich | Deputy Secretary of Health IT, CHHSA |
| Ron Jimenez | Associate Medical Director, Clinical Informatics, Santa Clara Valley Health & Hospital System |
| Scott Joslyn | CIO, Memorial Care |
| Charles Kennedy | VP, Health IT, Blue Cross of California |
| Rama Khalsa | Health Director, County of Santa Cruz |
| Sainam Khan | Altamed Health Services Corporation |
| Laura Landry | Executive Director, Long Beach Network for Health |
| Ronald Leeruangsri | County of Los Angeles Chief Executive Office |
| Ann Lindsay | Health Officer, Humboldt County |
| Mason Matthews | County of Los Angeles Chief Executive Office |
| Michael Minear | CIO, UC Davis Health System |
| Nancy Monk | SVP, Pub/Reg Affairs, United Health Care |
| Glen Moy | Sr. Program Officer, California Health Care Foundation |
| Kim Ortiz | Chief Deputy Director, Medi-Cal |
| Ray Otake | CIO, Community Health Center Network |
| Ray Parris | CIO, Golden Valley Health Center |
| Angela Roberts | VP Administrative Services, Altamed Health Services Corporation |
| Wayne Sass | CIO and Privacy Officer, Nautilus Healthcare Management Group |
| Lucia Savage | Assoc. General Counsel, United Health Care |
| Michael Schrader | COO, CenCal Health |
| Linette Scott | Deputy Director, CA Dept. of Public Health |
| Terri Shaw | Deputy Director, Children's Partnership |
| Sheila Shima | Deputy CEO for Health and Mental Health, County of Los Angeles Chief Executive Office |
| Patrick Sonn-Shiong | Founder, National Coalition for Health Information |
| Bill Spooner | CIO, Sharp Healthcare |
| Tom Williams | Executive Director, Integrated Healthcare Association |

Staff Present

| Name |
|---|
| Walter Sujansky |
| Tim Andrews |
| Peter Hung |